under-spending of the biennial appropriation for nursing facility rates, etc.

[Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-726, filed 9/25/98, effective 10/1/98.]

WAC 388-96-728 How will the nursing facility's "hold harmless" direct care rate be determined? For October 1, 1998, through June 30, 2000, under RCW 74.46.506 (5)(k), the "hold harmless" direct care rate is the nursing facility's nursing service component rate in effect on June 30, 1998, adjusted as follows:

(1) Subtract allowable therapy costs from the cost report year used to set the facility's June 30, 1998, nursing services rate; and

(2) Add all exceptional care offsets made to reported costs from the cost report year 1997.

The department shall adjust the therapy costs and exceptional care offsets for economic trends and conditions used to set the facility's June 30, 1998, rate.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 25 and RCW 74.46.800. 98-20-023, § 388-96-728, filed 9/25/98, effective 10/1/98.]

WAC 388-96-729 When will the department use the "hold harmless rate" to pay for direct care services? For October 1, 1998, through June 30, 2000, under RCW 74.46.506 (5)(k), the department will use the higher of the "hold harmless" direct care rate determined under WAC 388-96-728 or the direct care rate determined in accordance with RCW 74.46.506 (1) through (5)(g), to pay for direct care services.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 25 and RCW 74.46.800. 98-20-023, § 388-96-729, filed 9/25/98, effective 10/1/98.]

WAC 388-96-738 What default case mix group and weight must the department use for case mix grouping when there is no minimum data set resident assessment for a nursing facility resident? (1) When a resident:

(a) Dies before the facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - SSB. The department must use the case mix weight assigned to the special care case mix group - SSB;

(b) Is discharged to an acute care facility before the nursing facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - SSB. The department must use the case mix weight assigned to the special care case mix group - SSB; or

(c) Is discharged for a reason other than those noted above before the facility completes the resident's initial assessment, the department must assign the assessment to the case mix group BC1 with a case mix weight of 1.000.

(2) If the resident assessment is untimely as defined in RCW 74.46.501 and as defined by federal regulations, then the department must assign the case to the default case mix group of BC1 which has a case mix weight of 1.000.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-738, filed 9/25/98, effective 10/1/98.]

WAC 388-96-739 How will the department determine which resident assessments are Medicaid resident assessments? The department must identify a Medicaid resident assessment through the review of the minimum data set (MDS) payer source code. If the nursing facility codes the payer source as "Medicaid per diem," regardless of whether any other payer source codes are checked, then the department will count the case as a Medicaid resident assessment.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-739, filed 9/25/98, effective 10/1/98.]

WAC 388-96-740 What will the department use as the Medicaid case mix index when a facility does not meet the ninety percent minimum data set (MDS) threshold as identified in RCW 74.46.501? (1) If the nursing facility is newly Medicaid certified after the quarter which will serve as the basis for the Medicaid case mix index, then the department must use the industry average Medicaid case mix index for the quarter specified in RCW 74.46.501 (7)(c) as the facility's Medicaid average case mix index.

(2) If the nursing facility does not meet the ninety percent MDS threshold for any other reason, then the department must use the facility's prior quarterly Medicaid case mix index less five percent as the Medicaid case mix index.

(3) For October 1, 1998, through December 31, 1998, when the nursing facility's MDS data for April 1, 1998, through June 30, 1998, used to determine the nursing facility's direct care rate does not meet the ninety percent MDS threshold for any other reason, the department shall use the nursing facility's prior quarterly Medicaid case mix index as the Medicaid case mix index.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-740, filed 9/25/98, effective 10/1/98.]

WAC 388-96-741 When the nursing facility does not have facility average case mix indexes for the four quarters specified in RCW 74.46.501 (7)(b) for determining the cost per case mix unit, what will the department use to determine the nursing facility's cost per case mix unit? If the nursing facility:

(1) Is newly Medicaid certified after the four quarters specified in RCW 74.46.501 (7)(b), then the department must use the industry average case mix index for those four quarters as the facility's average case mix index.

(2) Existed during at least one of the four quarters and met the ninety percent threshold for at least one of the four quarters specified in RCW 74.46.501 (7)(b), then the department must use the facility's average case mix index for the quarter(s) that the facility met the ninety percent threshold.

(3) Existed during at least one of the four quarters and did not meet the ninety percent threshold for any of the four quarters, then the department must use the industry average case mix index as the facility's average case mix index.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-741, filed 9/25/98, effective 10/1/98.]

WAC 388-96-742 When will the department use licensed beds to compute the ninety percent minimum data set (MDS) threshold rather than a nursing facility's quarterly average census? The department will use the number of licensed beds to compute the ninety percent threshold of MDS data when:

(1) The reported census as a result of data entry errors exceeds the number of current licensed beds; or

(2) There is a significant discrepancy between the reported census and the number of current licensed beds. If the census is fifty percent of the number of licensed beds, a significant discrepancy exists.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-742, filed 9/25/98, effective 10/1/98.]

WAC 388-96-744 How will the department set the therapy care rate and determine the median cost limit per unit of therapy? (1) For a nursing facility that does not report units of therapy for the applicable cost report year, the department will set its nursing facility therapy care rate at $0.00 until units of therapy are submitted.

(2) After the nursing facility reports its units of therapy, the department will pay the nursing facility a rate beginning the effective date of the rate year, e.g., July 1.

(3) In a rebase year the nursing facility's units of therapy must be reported in the cost report used to rebase the rate. If reported later than the cost report due date, the department shall exclude the nursing facility's therapy costs from the array of costs use to set the median cost limit per unit of therapy.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 26 and RCW 74.46.800. 98-20-023, § 388-96-744, filed 9/25/98, effective 10/1/98.]

WAC 388-96-746 How much therapy consultant expense for each therapy type will the department allow to be added to the total allowable one-on-one therapy expense? (1) The department will multiply the actual patient days when greater than eighty-five percent or patient days at eighty-five percent occupancy by both:

(a) A nursing facility's adjusted therapy consulting costs per patient day; and

(b) The median adjusted therapy consulting cost plus ten percent.

The lesser of (a) or (b) of this subsection will be reasonable therapy consulting costs that the department shall add to the total allowable one-on-one therapy expense used to calculate the therapy care rate.

(2) To determine the median adjusted therapy consulting cost per type of therapy, the department shall:

(a) Divide Medicaid nursing facilities in the state into two peer groups:

(i) Those facilities located within a metropolitan statistical area, and

(ii) Those not located in a metropolitan statistical area. Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States Office of Management and Budget or other applicable federal office.

(b) Array the facilities in each peer group from highest to lowest based on their therapy consulting cost per patient day for each type of therapy.

(c) Determine the median total cost for therapy consulting per patient day costs by MSA and non-MSA peer group and add ten percent to that median cost.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 26 and RCW 74.46.800. 98-20-023, § 388-96-746, filed 9/25/98, effective 10/1/98.]

WAC 388-96-747 Constructed, remodeled or expanded facilities. (1) When a facility is constructed, remodeled, or expanded after obtaining a certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing home beds pursuant to RCW 70.38.115 (13)(a), the department shall determine actual and allocated allowable land cost and building construction cost. Payment for such allowable costs, determined pursuant to the provisions of this chapter, shall not exceed the maximums set forth in this subsection and in subsections (2) and (7) of this section. The department shall determine construction class and types through examination of building plans submitted to the department and/or on-site inspections. The department shall use definitions and criteria contained in the Marshall and Swift Valuation Service published by the Marshall and Swift Publication Company. Buildings of excellent quality construction shall be considered to be of good quality, without adjustment, for the purpose of applying these maximums.

(2) Construction costs shall be final labor, material, and service costs to the owner or owners and shall include:

(a) Architect's fees;

(b) Engineers' fees (including plans, plan check and building permit, and survey to establish building lines and grades);

(c) Interest on building funds during period of construction and processing fee or service charge;

(d) Sales tax on labor and materials;

(e) Site preparation (including excavation for foundation and backfill);

(f) Utilities from structure to lot line;

(g) Contractors' overhead and profit (including job supervision, workmen's compensation, fire and liability insurance, unemployment insurance, etc.);

(h) Allocations of costs which increase the net book value of the project for purposes of Medicaid payment;

(i) Other items included by the Marshall and Swift Valuation Service when deriving the calculator method costs.

(3) The department shall allow such construction costs, at the lower of actual costs or the maximums derived from the sum of the basic construction cost limit plus the common use area limit which corresponds to the type, class and number of total nursing home beds for the new construction, remodel or expansion. The maximum limits shall be calculated using the most current cost criteria contained in the *Marshall and Swift Valuation Service* and shall be adjusted forward to the midpoint date between award of the construction contract and completion of construction.

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(4) When some or all of a nursing facility's common-use areas are situated in a basement, the department shall exclude some or all of the per-bed allowance for common-use areas to derive the construction cost lid for the facility. The amount excluded will be equal to the ratio of basement common-use areas to all common-use areas in the facility times the common-use area limits determined in accordance with subsection (3) of this section. In lieu of the excluded amount, the department shall add an amount calculated using the calculator method guidelines for basements in nursing homes published in the *Marshall and Swift Valuation Service*.

(5) Subject to provisions regarding allowable land contained in this chapter, allowable costs for land shall be the lesser of:

(a) Actual cost per square foot, including allocations;

(b) The average per square foot land value of the ten nearest urban or rural nursing facilities at the time of purchase of the land in question. The average land value sample shall reflect either all urban or all rural facilities depending upon the classification of urban or rural for the facility in question. The values used to derive the average shall be the assessed land values which have been calculated for the purpose of county tax assessments; or

(c) Land value for new or replacement building construction or substantial building additions requiring the acquisition of land that commenced to operate on or after July 1, 1997, determined in accordance with RCW 74.46.360 (2) and (3).

(6) If allowable costs for construction or land are determined to be less than actual costs pursuant to subsections (1) and (7) of this section, the department may increase the amount if the owner or contractor is able to show unusual or unique circumstances having substantially impacted the costs of construction or land. Actual costs shall be allowed to the extent they resulted from such circumstances up to a maximum of ten percent above levels determined under subsections (3), (4), and (5) of this section for construction or land. An adjustment under this subsection shall be granted only if requested by the contractor. The contractor shall submit documentation of the unusual circumstances and an analysis of its financial impact with the request.

(7) If a capitalized addition or retirement of an asset will result in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement, the department shall use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity as long as the occupancy for the increased number of beds is at or above eighty-five percent. Subject to the provisions of this chapter and chapter 74.46 RCW, in no case shall the department use less than eighty-five percent occupancy of the facility's increased licensed bed capacity. If a capitalized addition, replacement, or retirement results in a decreased licensed bed capacity, WAC 388-96-709 will apply.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800. 98-20-023, § 388-96-747, filed 9/25/98, effective 10/1/98.]

WAC 388-96-757 Payment for veterans' homes. Payment rates to nursing facilities operated by the state of Washington, department of veterans' affairs shall be determined in accordance with chapter 74.46 RCW and this chapter as for all other facilities.

[Statutory Authority: RCW 74.09.120 and 74.46.800. 98-20-023, § 388-96-757, filed 9/25/98, effective 10/1/98; 93-19-074 (Order 3634), § 388-96-757, filed 9/14/93, effective 10/15/93.]

WAC 388-96-760 Upper limits to the payment rate. The average payment rate for the cost report year shall not exceed the contractor's average customary charges to the general public for the services covered by the payment rate for the same time period. The department will pay public facilities rendering such services free of charge or at a nominal charge according to the methods and standards set out in this chapter. The contractor shall provide as part of the annual cost report a statement of the average charges for the cost report year for services covered by the payment rate and supporting computations and documentation. The contractor shall immediately inform the department if its payment rate does exceed customary charges for comparable services. If necessary, the department will adjust the payment rate in accordance with RCW 74.46.531.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322, RCW 74.46.800 and 74.09.120. 98-20-023, § 388-96-760, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-760, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-760, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-760, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-760, filed 11/4/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-760, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-760, filed 1/9/78.]

WAC 388-96-762 Allowable land. (1) Beginning January 1, 1985, land associated with a nursing facility which is eligible for inclusion in net invested funds shall not exceed two acres for facilities located in a Metropolitan Statistical Area (MSA), as defined and determined by the United States Office of Management and Budget or other applicable federal office, and three acres for nursing facilities located outside such an area.

(2) The department may grant an exception to these limits if a contractor presents documentation deemed adequate by the department establishing a larger area of land is directly related to patient care. Requests for exceptions and any exceptions granted must be in writing.

(3) Requests for exceptions may be granted in the following cases:

(a) The area occupied by the nursing home building exceeds the allowable land area specified in subsection (1) of this section;

(b) The land is used directly in the provision of patient care;

(c) The land is maintained;

(d) The land is not subdivided or eligible for subdivision;

(e) The land is zoned for nursing home or similar use; and

(f) Other reasons exist which are deemed sufficient by the department.

[Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-762, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-762, filed 9/14/93, effective

10/15/93. Statutory Authority: RCW 74.46.800, 84-12-039 (Order 2105), § 388-96-762, filed 5/30/84.]

WAC 388-96-766 Notification of rates. The department will notify each contractor in writing of its prospective reimbursement rate. Unless otherwise specified at the time it is issued, the rate will be effective from the first day of the month in which it is issued until a new rate becomes effective. If a rate is changed as the result of an appeal in accordance with WAC 388-96-904, it will be effective as of the date the rate appealed from became effective.

[Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-766, filed 1/9/78.]

WAC 388-96-767 Appraisal values. If a contractor is unwilling or unable to provide and document the lessor's historical cost of leased assets, the department shall arrange for an appraisal of such assets to be conducted by the state of Washington department of general administration. If such an appraisal is conducted, it shall be the basis for all property and return on investment reimbursement, except that: If documentation subsequently becomes available to the department establishing the lessor's historical cost is less than the appraisal value, the historical cost shall be the basis for all property and return on investment reimbursement.

[Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-767, filed 5/30/84.]

WAC 388-96-771 Receivership. (1) If the nursing home is providing care to recipients of state medical assistance, the receiver shall:

(a) Become the Medicaid contractor for the duration of the receivership period;

(b) Assume all reporting responsibilities for new contractors;

(c) Assume all other responsibilities for new contractors set forth in this chapter; and

(d) Be responsible for the refund of Medicaid rate payments in excess of costs during the period of receivership.

(2) In establishing the prospective rate during receivership the department shall consider:

(a) Compensation, if any, ordered by the court for the receiver. Such compensation may already be available to the receiver through the rate as follows:

(i) The return on investment, or

(ii) The administrator's salary in the case of facilities where the receiver is also the administrator.

If these existing sources of compensation are less than what was ordered by the court, additional costs may be allowed in the rate up to the compensation amount ordered by the court.

(b) Start-up costs and costs of repairs, replacements, and additional staff needed for patient health, security, and welfare. To the extent such costs can be covered through return on investment, no additional monies will be added to the rate;

(c) Any other allowable costs as set forth in this chapter.

(3)(a) Upon order of the court, the department shall provide emergency or transitional financial assistance to a receiver not to exceed thirty thousand dollars.

(b) The department shall recover any emergency or transitional expenditure made by the department on behalf of a nursing home not certified to participate in the Medicaid Title XIX program from revenue generated by the facility which is not obligated to the operation of the facility.

(c) In order to help recover an emergency or transitional expenditure, regardless of whether the facility is certified to participate in the Medicaid Title XIX program or not, the department may:

(i) File an action against the former licensee or owner at the time the expenditure is made to recover such expenditure; or

(ii) File a lien on the facility or on the proceeds of the sale of the facility.

(4) If recommendations on receiver's compensation are solicited from the department by the court, the department shall consider the following:

(a) The range of compensation for nursing home managers;

(b) Experience and training of the receiver;

(c) The size, location, and current condition of the facility;

(d) Any additional factors deemed appropriate by the department.

(5) When the receivership terminates, the department may revise the nursing home's Medicaid reimbursement. The Medicaid reimbursement rate for:

(a) The former owner or licensee shall be what it was before receivership, unless the former owner or licensee requests prospective rate revisions from the department as set forth in this chapter; and

(b) Licensed replacement operators shall be determined consistent with rules governing prospective reimbursement rates for new contractors as set forth in this chapter.

[Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-771, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120. 88-06-085 (Order 2602), § 388-96-771, filed 3/2/88.]

WAC 388-96-776 Add-ons to the payment rate—Capital improvements. (1) The department shall grant an add-on to a payment rate for any capitalized additions or replacements made as a condition for licensure or certification; provided, the net rate effect is ten cents per patient day or greater.

(2) The department shall grant an add-on to a prospective rate for capitalized improvements done under RCW 74.46.431(12); provided, the legislature specifically appropriates funds for capital improvements for the biennium in which the request is made and the net rate effect is ten cents per patient day or greater. Physical plant capital improvements include, but are not limited to, capitalized additions, replacements or renovations made as a result of an approved certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing facility beds pursuant to RCW 70.38.115 (13)(a) or capitalized additions or renovations for the removal of physical plant waivers.

(3) Rate add-ons granted pursuant to subsection (1) or (2) of this section shall be limited in total amount each fiscal

year to the total current legislative appropriation, if any, specifically made to fund the Medicaid share of such rate add-ons for the fiscal year. Rate add-ons are subject to the provisions of RCW 74.46.421.

(4) When physical plant improvements made under subsection (1) or (2) of this section are completed in phases, the department shall not grant a rate add-on for any addition, replacement or improvement until each phase is completed and fully utilized for the purpose for which it was intended. The department shall limit rate add-on to only the actual cost of the depreciable tangible assets meeting the criteria of RCW 74.46.330 and as applicable to that specific completed and fully utilized phase.

(5) When the construction class of any portion of a newly constructed building will improve as the result of any addition, replacement or improvement occurring in a later, but not yet completed and fully utilized phase of the project, the most appropriate construction class, as applicable to that completed and fully utilized phase, will be assigned for purposes of calculating the rate add-on. The department shall not revise the rate add-on retroactively after completion of the portion of the project that provides the improved construction class. Rather, the department shall calculate a new rate add-on when the improved construction class phase is completed and fully utilized and the rate add-on will be effective in accordance with subsection (9) of this section using the date the class was improved.

(6) The department shall not add on construction fees as defined in WAC 388-96-747 and other capitalized allowable fees and costs as related to the completion of all phases of the project to the rate until all phases of the entire project are completed and fully utilized for the purpose it was made. At that time, the department shall add on these fees and costs to the rate, effective no earlier than the earliest date a rate add-on was established specifically for any phase of this project. If the fees and costs are incurred in a later phase of the project, the add-on to the rate will be effective on the same date as the rate add-on for the actual cost of the tangible assets for that phase.

(7) The contractor requesting an adjustment under subsection (1) or (2) shall submit a written request to the office of rates management separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). A complete written request shall include the following:

(a) A copy of documentation requiring completion of the addition or replacements to maintain licensure or certification for adjustments requested under subsection (1) of this section;

(b) A copy of the new bed license, whether the number of licensed beds increases or decreases, if applicable;

(c) All documentation, e.g., copies of paid invoices showing actual final cost of assets and/or service, e.g., labor purchased as part of the capitalized addition or replacements;

(d) Certification showing the completion date of the capitalized additions or replacements and the date the assets were placed in service per RCW 74.46.360;

(e) A properly completed depreciation schedule for the capitalized additions or replacement as provided in this chapter;

(f) A written justification for granting the rate increase; and

(g) For capitalized additions or replacements requiring certificate of need approval, a copy of the approval and description of the project.

(8) The department's criteria used to evaluate the request may include, but is not limited to:

(a) The remaining functional life of the facility and the length of time since the facility's last significant improvement;

(b) The amount and scope of the renovation or remodel to the facility and whether the facility will be better able to serve the needs of its residents;

(c) Whether the improvement improves the quality of living conditions of the residents;

(d) Whether the improvement might eliminate life safety, building code, or construction standard waivers;

(e) Prior survey results; and

(f) A review of the copy of the approval and description of the project.

(9) The department shall not grant a rate add-on effective earlier than sixty days prior to the receipt of the initial written request by the office of rates management and not earlier than the date the physical plant improvements are completed and fully utilized. The department shall grant a rate add-on for an approved request as follows:

(a) If the physical plant improvements are completed and fully utilized during the period from the first day to the fifteenth day of the month, then the rate will be effective on the first day of that month; or

(b) If the physical plant improvements are completed and fully utilized during the period from the sixteenth day and the last day of the month, the rate will be effective on the first day of the following month.

(10) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor shall submit the requested information within fifteen calendar days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the add-on request by providing all the requested documentation and information within the fifteen calendar days from the date of receipt of notification, the department shall deny the request for failure to complete.

(11) If, after the denial for failure to complete, the contractor submits a written request for the same project, the date of receipt for the purpose of applying subsection (9) of this section will depend upon whether the subsequent request for the same project is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same project is:

(a) Complete, then the date of the first request may be used when applying subsection (9) of this section; or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (9) of this section even though the physical plant improvements may be completed and fully utilized prior to that date.

(12) The department shall respond, in writing, not later than sixty calendar days after receipt of a complete request.

(13) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

(14) When any physical plant improvements made under subsection (1) or (2) of this section results in a change in licensed beds, any rate add-on granted will be subject to the provisions regarding the number of licensed beds, patient days, occupancy, etc., included in this chapter and chapter 74.46 RCW.

(15) All rate components to fund the Medicaid share of nursing facility new construction or refurbishing projects costing in excess of one million two hundred thousand dollars, or projects requiring state or federal certificate of need approval, shall be based upon a minimum facility occupancy of eighty-five percent for the direct care, therapy care, support services, operations and property cost centers, and the return on investment (ROI) rate component, during the initial rate period in which the adjustment is granted. These same component rates shall be based upon a minimum facility occupancy of eighty-five percent for all rate periods after the initial rate period.

(16) When a capitalized addition or replacement results in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement:

(a) The department shall for:

(i) Property, use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(ii) The financing allowance, multiply the net invested funds by ten percent and divide by the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(b) The anticipated resident occupancy for the increased number of beds must be at or above eighty-five percent. In all cases the department shall use at least eighty-five percent occupancy of the facility's increased licensed bed capacity.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800. 98-20-023, § 388-96-776, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.465. 97-17-040, § 388-96-776, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-776, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-776, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-776, filed 5/26/94, effective 6/26/94.]

WAC 388-96-777 Add-ons to the prospective rate—Initiated by the department. (1) The department shall initiate all rate add-ons granted under this section. Contractors may not request and be approved a rate add-on under this section.

(2) Rate add-ons the department grants under the authority of this section shall be for costs to implement:

(a) Program changes that the director of nursing home services, aging and adult services administration determines a rate add-on is necessary to accomplish the purpose of the change and announces same in a written directive to the chief of the office of rates management; or

(b) Changes in either the state or federal statutes or regulations or directives that the director of management services, aging and adult services administration determines requires a rate add-on to implement and directs in writing the chief of the office of rates management to implement.

(3) Changes made under this section are subject to review under WAC 388-96-901 and 388-96-904; *provided*, the issue is not whether a rate add-on should have been granted.

(4) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

[Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-777, filed 5/26/94, effective 6/26/94.]

WAC 388-96-901 Disputes. (1) If a contractor wishes to contest the way in which a statute or department rule relating to the nursing facility Medicaid payment system was applied to the contractor by the department, the contractor shall pursue the administrative review process prescribed in WAC 388-96-904.

(a) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW subject to administrative review under WAC 388-96-904 include but are not limited to:

(i) Determining a nursing facility payment rate;

(ii) Calculating a nursing facility settlement;

(iii) Imposing a civil fine on the nursing facility;

(iv) Suspending payment to a nursing facility; or

(v) Refusing to contract with a nursing facility.

(b) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW not subject to administrative review under WAC 388-96-904 include but are not limited to those taken under the authority of RCW 74.46.421 and sections of this chapter implementing RCW 74.46.421.

(2) The administrative review process prescribed in WAC 388-96-904 shall not be used to contest or review unrelated or ancillary department actions, whether review is sought to obtain a ruling on the merits of a claim or to make a record for subsequent judicial review or other purpose. If an issue is raised that is not subject to review under WAC 388-96-904, the presiding office shall dismiss such issue with prejudice to further review under the provisions of WAC 388-96-904, but without prejudice to other administrative or judicial review as may be provided by law. Unrelated or ancillary actions not eligible for administrative review under WAC 388-96-904 include but are not limited to:

(a) Challenges to the adequacy or validity of the public process followed by department in proposing or making a change to the nursing facility Medicaid payment rate methodology, as required by 42 U.S.C. 1396a (a)(13)(A) and WAC 388-96-718;

(b) Challenges to the nursing facility Medicaid payment system that are based in whole or in part on federal laws, regulations, or policies;

(c) Challenges to a contractor's rate that are based in whole or in part of federal laws, regulations, or policies;

(d) Challenges to the legal validity of a statute or regulation;

(e) Issues relating to case mix accuracy review of minimum data set (MDS) nursing facility resident assessments, which shall be limited to separate administrative review under the provisions of WAC 388-96-905;

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(f) Quarterly rate updates to reflect changes in a facility's resident case mix; and

(g) Issues relating to any action of the department affecting a Medicaid beneficiary or provider that were not commenced by the office of rates management, aging and adult services administration, for example, entitlement to or payment for durable medical equipment or other services.

(3) If a contractor wishes to challenge the legal validity of a statute or regulation relating to the nursing facility Medicaid payment system, or wishes to bring a challenge based in whole or in part on federal law, it must bring such action de novo in a court of proper jurisdiction as may be provided by law.

[Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41. 98-20-023, § 388-96-901, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-901, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-901, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-901, filed 10/13/82; Order 1262, § 388-96-901, filed 12/30/77.]

WAC 388-96-904 Administrative review—Adjudicative proceeding. (1) Contractors seeking to appeal or take exception to an action or determination of the department, under authority of this chapter or chapter 74.46 RCW, relating to the contractor's payment rate, audit or settlement, or otherwise affecting the level of payment to the contractor, or seeking to appeal or take exception to any other adverse action taken under authority of this chapter or chapter 74.46 RCW eligible for administrative review under this section, shall request an administrative review conference in writing within twenty-eight calendar days after receiving notice of the department's action or determination. The department shall deem the contractor to have received the department's notice five calendar days after the date of the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt shall be used to determine timeliness of the contractor's request for an administrative review conference. The contractor's request for administrative review shall:

(a) Be signed by the contractor or by a partner, officer, or authorized employee of the contractor;

(b) State the particular issues raised; and

(c) Include all necessary supporting documentation or other information.

(2) After receiving a request for administrative review conference that meets the criteria in subsection (1) of this section, the department shall schedule an administrative review conference. The conference may be conducted by telephone.

(3) At least fourteen calendar days prior to the scheduled date of the administrative review conference, the contractor must supply any additional or supporting documentation or information upon which the contractor intends to rely in presenting its case. In addition, the department may request at any time prior to issuing a determination any documentation or information needed to decide the issues raised, and the contractor must comply with such a request within fourteen calendar days after it is received. The department may extend this period up to fourteen additional calendar days for good cause shown if the contractor requests an extension in writing received by the department before expiration of the initial fourteen-day period. The department shall dismiss issues that cannot be decided or resolved due to a contractor's failure to provide requested documentation or information within the required period.

(4) The department shall, within sixty calendar days after conclusion of the conference, render a determination in writing addressing the issues raised. If the department is waiting for additional documentation or information promised by or requested from the contractor pursuant to subsection (3) of this section, the sixty-day period shall not commence until the department's receipt of such documentation or information or until expiration of the time allowed to provide it. The determination letter shall include a notice of dismissal of all issues which cannot be decided due to a contractor's failure to provide documentation or information promised or requested.

(5) A contractor seeking further review of a determination issued pursuant to subsection (4) of this section shall apply for an adjudicative proceeding, in writing, signed by one of the individuals authorized by subsection (1) of this section, within twenty-eight calendar days after receiving the department's administrative review conference determination letter. A review judge or other presiding officer employed by the department's board of appeals shall conduct the adjudicative proceeding.

The department shall deem the contractor to have received the department's determination five calendar days after the date of the administrative review determination letter, unless proof of the date of receipt of the letter exists, in which case the actual date of receipt shall be used to determine timeliness of the contractor's application for an adjudicative proceeding. The contractor shall attach to its application for an adjudicative proceeding the department's administrative review conference determination letter. A contractor's application for an adjudicative proceeding shall be addressed to the department's board of appeals.

(6) Except as authorized by subsection (7) of this section, the scope of an adjudicative proceeding shall be limited to the issues specifically raised by the contractor at the administrative review conference and addressed on the merits in the department's administrative review conference determination letter. The contractor shall be deemed to have waived all issues or claims that could have been raised by the contractor relating to the challenged determination or action, but which were not pursued at the conference and not addressed in the department's administrative review conference determination letter. In its request for an adjudicative proceeding or as soon as practicable, the contractor must specify its issues.

(7) If the contractor wishes to have further review of any issue not addressed on its merits, but instead dismissed in the department's administrative review conference determination letter, for failure to supply needed, promised, or requested additional information or documentation, or because the department has concluded the request was untimely or otherwise procedurally defective, the issue shall be considered by the presiding officer for the purpose of upholding the department's dismissal, reinstating the issue and remanding for further agency staff action, or reinstating the issue and rendering a decision on the merits.

(8) An adjudicative proceeding shall be conducted in accordance with this chapter, chapter 388-08 WAC and chapter 34.05 RCW. In the event of a conflict between hearing requirements in chapter 74.46 RCW and chapter 388-96 WAC specific to the nursing facility Medicaid payment system on the one hand and general hearing requirements in chapter 34.05 RCW and chapter 388-08 WAC on the other hand, the specific requirements of chapter 74.46 RCW and chapter 388-96 WAC shall prevail. The presiding officer assigned by the department's board of appeals to conduct an adjudicative proceeding and who conducts the proceeding shall render the final agency decision.

(9) At the time an adjudicative proceeding is being scheduled for a future time and date certain, or at any appropriate stage of the prehearing process, the presiding officer shall have authority, upon the motion of either party or the presiding officer's own motion, to compel either party to identify specific issues remaining to be litigated.

(10) If the presiding officer determines there is no material issue(s) of fact to be resolved in a case, the presiding officer shall have authority, upon the motion of either party or the presiding officer's own motion, to decide the issue(s) presented without convening or conducting an in-person evidentiary hearing. In such a case, the decision may be reached on documentation admitted to the record, party admissions, written or oral stipulation(s) of facts, and written or oral argument.

(11) The board of appeals shall issue an order dismissing an adjudicative proceeding requested under subsection (5) of this section, unless within two hundred seventy calendar days after the board of appeals receives the application for an adjudicative proceeding:

(a) All issues have been resolved by a written settlement agreement between the contractor and the department signed by both and filed with the board of appeals; or

(b) An adjudicative proceeding has been held for all issues not resolved and the evidentiary record, including all rebuttal evidence and post-hearing or other briefing, is closed.

This time limit may be extended one time thirty additional calendar days for good cause shown upon the motion of either party made prior to the expiration of the initial two hundred seventy day period. It shall be the responsibility of the contractor to request that hearings be scheduled and ensure that settlement agreements are signed and filed with the board of appeals in order to comply with the time limit set forth in this subsection.

(12) Any party dissatisfied with a decision or an order of dismissal of the board of appeals may file a petition for reconsideration within ten calendar days after the decision or order of dismissal is served on such party. The petition shall state the specific grounds upon which relief is sought. The time for seeking reconsideration may be extended by the presiding officer for good cause upon motion of either party. The presiding officer shall rule on a petition for reconsideration and may seek additional argument, briefing, testimony, or other evidence if deemed necessary. Filing a petition for reconsideration shall not be a requisite for seeking judicial review, however, if a petition is filed by either party, the agency decision shall not be deemed final until a ruling is made by the presiding officer.

(13) A contractor dissatisfied with a decision or an order of dismissal of the board of appeals may file a petition for judicial review pursuant to RCW 34.05.570(3) or other applicable authority.

[Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41. 98-20-023, § 388-96-904, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-904, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-904, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-904, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-904, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.09.120. 90-04-071 (Order 3003), § 388-96-904, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-904, filed 12/21/88. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-904, filed 12/23/87. Statutory Authority: RCW 34.04.020. 84-05-040 (Order 2076), § 388-96-904, filed 2/17/84. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-904, filed 10/13/82; Order 1262, § 388-96-904, filed 12/30/77.]

WAC 388-96-905 Case mix accuracy review of MDS nursing facility resident assessments. (1) The department shall perform periodic nursing facility on-site accuracy reviews of minimum data set (MDS) assessments of nursing facility residents, for the purpose of verifying the accuracy of facility case mix data used to establish and update Medicaid payment rates, and for other purposes the department may deem appropriate.

(2) Contractors, their representatives, and authorized nursing facility personnel may ask questions and raise concerns with the quality assurance nurse (QAN) or other designated department representative at the time a case mix accuracy review is conducted. Contractors, their representatives and authorized nursing facility personnel should attempt to resolve any differences and provide additional documentation, information or clarification prior to the case mix accuracy review exit conference.

(3) Upon completing a case mix accuracy review, the QAN shall hold an exit conference to inform the facility of the QAN's observations and preliminary findings. MDS inaccuracies, if any, will be identified and the findings that substantiate these inaccuracies shall be described.

(4) Within five working days after the case mix accuracy review exit conference is held, the nursing facility district manager (DM) for the facility's district shall send the case mix accuracy review decision letter to the nursing facility administrator at the facility address. The case mix accuracy review decision letter shall be sent certified mail, return receipt requested, shall describe in detail the QAN's findings, and shall identify the:

(a) Resident assessments that were reviewed;

(b) RUG-III or other applicable case mix grouping that was determined for the resident assessments reviewed;

(c) Changes in assigned classification, if any, that were made for residents whose assessments were reviewed;

(d) Right of the contractor to appeal any disagreement with the case mix accuracy review decision to the department's case mix accuracy review administrator or his or her delegate;

(e) Where to send an appeal request; and

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(ii) The time limit for requesting an appeal.

(5) If the contractor intends to appeal the DM's case mix accuracy review decision letter, the appeal request must be in writing and mailed to the department's case mix accuracy administrator within ten calendar days after receipt of the case mix accuracy review decision letter. The appeal request letter shall:

(a) Be signed by the contractor or by a partner, officer, or authorized employee of the contractor;

(b) State the particular issue(s) raised, including any explanation or basis for disagreeing with the department's findings or actions.

(6) Prior to the informal administrative hearing, the case mix accuracy review administrator shall have no involvement in the case mix accuracy review decision.

(7) Upon receiving a timely appeal request, the administrator shall review any documentation and information submitted with the request, and contact the contractor by telephone to schedule an informal administrative hearing. The purpose of this informal hearing is to give the contractor one opportunity to present information which might warrant modification or deletion of resident-specific accuracy findings resulting from the case mix accuracy review. The scope of the informal administrative hearing shall be limited to clinical issues of resident need and assessment. Nonclinical issues beyond the scope of appeal include, but are not limited to:

(a) Any remedies or negative actions imposed by the department to rectify practices or inaccuracies;

(b) Alleged inconsistencies in the accuracy review process;

(c) Challenges to the authority or adequacy of the case mix accuracy review process; and

(d) Payment rate issues or other adverse actions subject to review under WAC 388-96-904.

(8) On or before the informal hearing date, the contractor must submit all necessary supporting documentation or other information to the case mix accuracy review administrator. The administrator may request additional information or documentation from the contractor at any time before issuing the final, informal hearing decision. The contractor shall provide all information or documentation within the time limits established by this section, or by the administrator. In the event that the contractor fails to submit the required documentation for a claim or issue within the specified time limits, the accuracy review administrator shall dismiss the claim or issue with prejudice.

(9) The informal case mix accuracy review administrative hearing shall be conducted in person, unless both the contractor and the department agree that it can be conducted by telephone.

(10) Within ten days after the informal administrative hearing or within ten days after receipt of any additional information or documentation requested, whichever is later, the case mix accuracy review administrator shall send the appeal decision in writing to the nursing facility administrator at the facility address. The appeal decision letter shall be sent regular mail and shall:

(a) Be the final agency decision of the department;

(b) Be based on the independent judgment of the case mix accuracy review administrator who conducted the informal administrative hearing and reviewed all information and documentation; and

(c) Recite the right of the contractor to seek judicial review under the state's Administrative Procedure Act (chapter 34.05 RCW).

(11) A contractor dissatisfied with the final agency decision issued by the case mix accuracy review administrator may file a petition for judicial review pursuant to RCW 34.05.570(3) or other applicable authority.

[Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41 and RCW 74.46.800. 98-20-023, § 388-96-905, filed 9/25/98, effective 10/1/98.]

Chapter 388-97 WAC
NURSING HOMES

WAC

CHAPTER 74.46 RCW

NURSING HOME AUDITING AND COST REIMBURSEMENT ACT OF 1980

Sections

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